PLAN DOCUMENT,
SUMMARY PLAN DESCRIPTION
AND
ADMINISTRATIVE WRAPPER

HANFORD RETIREE
WELFARE BENEFIT PLANS

Offered under the
HANFORD EMPLOYEE
WELFARE TRUST (HEWT)

January 1, 2011

This plan document and summary plan description contains information the Plan Administrator is required to provide to you under federal law.

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INTRODUCTION

This document is the formal plan document and summary plan description under which the welfare benefit plans available to retirees and their eligible dependents (the "Plans") listed in Attachment A (the "Plans Chart") and offered under the Hanford Employee Welfare Trust (the "Trust") are administered. A separate document governs benefits provided to active employees and their dependents. As used in this document, "we," "us" and "our" refers to the Plan Administrator. "You" and "your" are referring to covered retirees and their dependents.

This document has been amended and restated effective January 1, 2011 to reflect the adoption of a Health Reimbursement Arrangement for retirees and their spouses who are at least age 65 and eligible for Medicare Parts A and B.

This document along with the benefit summaries, certificates of coverage and other plan documents (collectively, the "SPDs") contain important information about your rights and obligations under federal law and under the Plans and the procedures you need to follow if you have questions about your benefits or if you disagree with a decision on your claim for benefits.

Benefits under the Plans are provided through the Trust. The Trust has been adopted by the employers listed on Attachment B (the "Sponsors Chart"). They are the Sponsors of the Plans. You are receiving this document because your former employer is one of the Sponsors of the Plans.

The Sponsors have appointed the Board of Trustees of the Trust as the Plan Administrator of the Plans. Mission Support Alliance, LLC ("MSA") has responsibility under their Contract with the United States Department of Energy (the "DOE") for administering the Plans. The Board of Trustees has delegated certain administrative responsibilities to MSA. Other entities are involved in the insurance and/or administration of the Plans as well. These are described in the Plans Chart.

You have received additional summaries governing the Plans in which you are eligible to participate either electronically or in writing. If you received them electronically you are entitled to receive printed copies per a written request to the following address: HEWT, Attn: Plan Administrator, Post Office Box 650 (MSIN H2-23), Richland, Washington 99352. The SPDs provide detailed information about the benefits to which you are entitled and steps you must take to obtain those benefits. The SPDs are incorporated herein by this reference. If there are conflicts between the language of the SPDs and this document, the terms of this document control. You may also request official additional documents, insurance contracts, trust agreements and other documents which legally govern the operation of the Plans (the "Plan Documents"). This document is intended to be read in conjunction with the SPDs and other documents, except as otherwise expressly provided.

DESCRIPTION OF THE PLANS

The names of the Plans (and, if different, the name by which the Plans are commonly known), Plan number assigned by the Board of Trustees, and the types of the Plans (medical and life insurance) are described in the Plans Chart (Attachment A).

The following benefit programs are available to retirees on and after January 1, 2011. Refer to each plan's Summary Plan Description for details.

Medical:

Retirees under age 65. Retirees who are not yet eligible for Medicare by virtue of age (i.e., under age 65) can choose from the following two plans for themselves and their eligible dependents who are under age 65. Plans, plan provisions, and rates are subject to change. If you are under age 65 and eligible for Medicare, please contact the Plan Administrator for further information.

1. United Healthcare (UHC) Preferred Provider Option (PPO) Plan

This plan covers most expenses for health care services from any qualified provider. The plan pays a majority of the incurred medical expenses after an annual deductible has been met. Retirees electing this plan can receive medical care from any qualified provider. Under the PPO, the reimbursement is greater if care is received from one of the network providers nationwide who are participants in the PPO.

2. Group Health Cooperative (GH) Options Point of Service (POS) Plan

This plan offers members a combination of in- network managed services found in the GH POS and "out-of-network" services which can be from any qualified provider. Contact GH as to availability of coverage outside of GH service area and the Certificate of Coverage plan provisions.

Retirees age 65 and older. Retirees and their spouses who are eligible for Medicare because of age (i.e., age 65 or older) are eligible to participate in the HEWT Retiree Health Reimbursement Arrangement. Once a retiree or a retiree's spouse is eligible to participate in the HEWT Retiree Health Reimbursement Arrangement, he or she is no longer eligible for HEWT group post-retirement insurance coverage.

- **Retiree Health Reimbursement Arrangement—Generally**

The HEWT has adopted a Retiree Health Reimbursement Arrangement program to assist eligible retirees and their eligible spouses in paying for the cost of uninsured medical expenses, including premiums for health care coverage. An individual is eligible for the HEWT Retiree Health Reimbursement Arrangement upon retirement after they have attained age 65 and enrolled in Medicare Parts A and B. You as a retiree are automatically enrolled in the HEWT Retiree Health Reimbursement Arrangement when you become eligible and notify ExtendHealth. To be enrolled, you must provide

ExtendHealth with a copy of your Medicare card. You must elect coverage for your spouse upon his or her attainment of age 65 and enrollment in Medicare Parts A and B.

- **Benefits Available Under the HEWT Retiree Health Reimbursement Arrangement**

Your former Employer will credit an account held in your and/or your eligible spouse's name under the HEWT with a flat dollar amount each year. The amount credited to your account in the first year that you participate will be prorated, based on your date of enrollment. The amount in your account and, if applicable, your spouse's account, can be used to reimburse you and/or your eligible spouse for the cost of uninsured medical expenses, which includes any cost of premiums for health care coverage and/or Medicare Part D. The same dollar amount will be credited to the HEWT Retiree Health Reimbursement Arrangement for all participants.

The amount that your former employer will credit to your and/or your eligible spouse's accounts will be determined before the beginning of each Plan Year.

You may submit a claim to ExtendHealth for reimbursement for the cost of uninsured medical expenses that you or your eligible spouse incur each month.

Unused amounts credited to your account in the HEWT Retiree Health Reimbursement Arrangement may be carried over from year to year. Any amount credited to the HEWT Retiree Health Reimbursement Arrangement may not be used for reimbursement for any expense other than the cost of your or your eligible spouse's uninsured medical costs, which includes the cost of premiums for group post-retirement health care coverage.

Life Insurances:

- Basic Group Life Insurance for Retirees under the age of 65

  At retirement, eligible participants under the age of 65 may elect one of the following levels of coverage:

  1. One times annual base pay rate as of the date of retirement, rounded up to the nearest $1,000, to maximum of $50,000. Participants are responsible for paying 50% of the total premium for coverage in excess of $15,000.

  2. Basic, HEWT-sponsored coverage in the amount of $15,000, which is currently provided at no cost to the participant. This coverage may not be increased.

- Accelerated Life Insurance Benefit (ALIB)

An Accelerated Life Insurance Benefit is available to retirees. If an eligible participant is diagnosed by two unaffiliated physicians as terminally ill, with a life expectancy of

twenty-four (24) months or less, this benefit provides for a payment of 50% of the Basic Life Insurance coverage amount in force at the time of the claim. This benefit will be available in the form of a one-time payment in the insured participant's lifetime. Any death benefit payable under the Basic Life insurance policy at the time of the participant's death will be reduced by the amount of the payment made under this accelerated provision. For eligibility rules and definitions, refer to the applicable certificate of coverage.

At age 65 coverage is reduced as provided below.

- Basic Group Life Insurance for Retirees age 65 and older

  At retirement, participants 65 and older may elect one of the following levels of coverage:

  - The lower of $15,000, or one-half of your annual base pay rate at the time you retire. Coverage is currently provided at no cost to eligible retirees who are age 65 and older.

  - Retirees who retired prior to their 65th birthday and elected coverage at the time they retired are eligible to continue their coverage upon reaching their 65th birthday. The level of coverage is subject to the same provisions outlined above.

- Dependent Life Insurance

  Retirees under age 65 may continue dependent life insurance for spouse and dependent children if enrolled at the time of retirement. Coverage is discontinued upon retiree's age of 65.

PLAN SPONSORS

The names of the Sponsors, their addresses and their Employer Identification Numbers ("EINs") assigned by the Internal Revenue Service are described in the Sponsors Chart (Attachment B).

In addition, participants and beneficiaries may receive from the Plan Administrator, upon written request, information as to whether a particular employer is a Sponsor of the Plan and, if the employer is a Plan Sponsor, the Sponsor's address.

EMPLOYER IDENTIFICATION NUMBER AND PLAN IDENTIFICATION NUMBER

The Employer Identification Number assigned to the Trust by the Internal Revenue Service is 91-2017261. The Plan Identification Number is 551.

PLAN TRUSTEES

The name, title and address of the principal place of business of the trustees of the Plans is:

Board of Trustees of the Hanford Employee Welfare Trust
P.O. Box 650, MSIN: H2-23
Richland, WA 99352

PLAN ADMINISTRATOR

The designated Plan Administrator of the Plans is the Board of Trustees of the Trust. The rights, duties, powers, and authority of the Board of Trustees is described in the Hanford Employee Welfare Trust Agreement (the "Trust Agreement"). All of the Trustees are representatives of the Sponsors (including your Employer) who establish and maintain the Plans.

The name, address and telephone number of the Plan Administrator is:

Plan Administrator
P.O. Box 650, MSIN: H2-23
Richland, WA 99352
Attn: Heather Goldie-Baker
Telephone: (509) 372-1385

PLAN ADMINISTRATOR'S DISCRETION

In carrying out its responsibilities under the Plans, the Plan Administrator has the exclusive responsibility and full discretionary authority to control the operation and administration of the Plans and to make all fiduciary decisions under the Plans, and it has all power necessary to accomplish such purposes. These powers include, but are not limited to:

- To make and enforce such rules and regulations as in its sole and absolute and uncontrolled discretion it deems necessary or proper for the efficient administration of the Plans that are not inconsistent with the terms of the Plans or the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

- To interpret the Plan documents in its discretion and its interpretation in good faith. Such interpretation is final and conclusive on all persons claiming benefits under the Plans.

- To use, employ, discharge or consult with one or more individuals, corporations or other entities with respect to advice regarding any responsibility, obligation or duty in connection with the Plan.

- To allocate fiduciary responsibilities by written instrument signed in the same manner as provided for delegations.

- To designate other individuals, corporations or other entities to carry out fiduciary responsibilities, obligations and duties under the Plan, and to revoke, modify or change any such delegation, revocation or modification by written instrument.

In carrying out its responsibilities, the Plan Administrator shall be fully protected to the fullest extent permitted under ERISA. In the event of any delegation in accordance with the above, no fiduciary shall be liable for any act or action, whether of commission or omission, taken by the person to whom the delegation is made. Fiduciary responsibilities shall be exercised severally and not jointly and each fiduciary's powers, duties, obligations and responsibilities shall be limited to those specifically allocated to such fiduciary or in accordance with the terms of this document.

PLAN RECORDS AND PLAN YEAR

The fiscal records for all Plans are maintained and reported on a twelve-month period of time, known as the Plan Year. The Plan Year begins on January 1 and ends on December 31.

SOURCE AND AMOUNT OF CONTRIBUTIONS

The source of contributions for each Plan is described in the Plans Chart (Attachment A). Depending on the Plan, contributions are made entirely by the Sponsors, participants, or partly by the Sponsors and partly by the participants. Therefore, plan provisions and contribution structures are subject to change. The Sponsors will determine, from time to time, what portion of the benefits will be paid directly by the Sponsors and what portion will be paid by the participants. Any amounts paid by a Sponsor will be paid out of such Sponsor's general assets.

PAYMENT OF BENEFITS

How benefits are paid under each Plan (i.e., the method of payment of benefits) is described for each Plan in the Plans Chart (Attachment A). The Chart provides the name of any insurance company, trust fund or other institution, organization, or entity that maintains a fund on behalf of a Plan or through which a Plan is funded or benefits are provided.

You should read the Plans Chart to understand exactly how benefits are paid for each Plan in which you participate. However, the following provides some general background.

The primary function of the Trust is to receive and hold Sponsor and participant contributions to the Plans, to pay insurance premiums or claims under the Plans and Plan expenses, as applicable. However, the Trust is not solely responsible for payment of benefits under the Plans. Benefits may be payable by an insurance company, the Sponsors (i.e., your former Employer) or a combination of both, depending on whether the Plan is insured, self-insured or partly insured and partly self-insured.

Some of the Plans under which your benefits are provided are Insured, as described on the Plans Chart (Attachment A). **This means that only the insurance company is responsible for**

payment of those benefits. Your former Employer is not responsible for payment of any benefits under the Insured Plans.

Some of the Plans under which your benefits are provided are Self-Insured by the Sponsors, as described on the Plans Chart (Attachment A). **This means that only your former Employer and the Trust are responsible for payment of those benefits.** Sponsors other than your former Employer are not responsible for payment of your benefits under the Self-Insured Plans.

Although MSA may administer aspects of a Plan, it only has responsibility for payment of your benefits if MSA is your former Employer and the Plan is self-insured by MSA.

DESCRIPTION OF BENEFITS

A description or summary of the benefits for each Plan is contained in a separate SPD, certificate of coverage, or benefit summary for each Plan. These documents may also make reference to schedules of benefits. These SPDs, certificates of coverage, or benefit summaries are available without cost to any participant or beneficiary who so requests.

ELIGIBILITY FOR BENEFITS

Effective January 1, 2004, newly hired employees are not eligible to participate in the group (medical and life insurance) plans described in this document. An employee hired before January 1, 2004, who has a break in service and is rehired by an employer Sponsor hereunder within 5 years of his or her termination date may regain eligibility for benefits described in this document if he or she otherwise meets the applicable age and service requirements.

A rehired retiree, eligible for post-retirement medical coverage, retains their eligibility for post-retirement medical coverage upon re-retirement at the existing rate structure and plan provisions, in place, at the time of re-retirement.

If you were hired, and in some circumstances re-hired, before January 1, 2004, you are eligible to participate in the applicable Plans described in the Plans Chart (Attachment A) if you are an eligible retiree from a Plan Sponsor or former Plan Sponsor. Your dependents may also be eligible. To be eligible for coverage under the HEWT post-retirement insurance and participation in the HEWT Retiree Health Reimbursement Arrangement, you must meet the following criteria at the time of separation from employment:

- Eligible for coverage with an employer Sponsor prior to termination;
- Eligible employee in good standing;
- Be age 55, with 10 years of pension vesting service;
- Make coverage elections when eligible; and
- Make coverage elections prior to termination of service.

Office and Professional Employees International Union (OPEIU) represented employees are not eligible for retiree medical coverage or life insurance coverage.

Employees under investigation and/or discharged for cause are not eligible for retiree medical coverage or life insurance coverage.

Effective January 1, 2011, retirees who are age 65 or older and who are eligible for and enrolled in Medicare are eligible for the HEWT Retiree Health Reimbursement Arrangement. Once a retiree attains age 65 and enrolls in Medicare, he or she will no longer be eligible for HEWT post-retirement insurance coverage other than the HEWT Retiree Health Reimbursement Arrangement.

Employees employed by Washington Closure Hanford, LLC (WCH) or Eberline Services Hanford, Inc. (ESHI) are not eligible to participate in the Plans described in this document regardless of whether they were previously employed by a Plan Sponsor prior to January 1, 2004, unless the employee was employed by a Plan Sponsor prior to January 1, 2004, and was subsequently employed by WCH or ESHI at the close of contract transition (August 27, 2005). These employees are hereafter Incumbents. For the purposes of this provision, Incumbents will be eligible to participate in the Plans if they satisfy the age, service and election requirements above before or after August 27, 2005. An Incumbent or an employee who is not an Incumbent will have the enrollment and opt-out rights described below and on rehire by a Sponsor other than WCH or ESHI will have the five (5) year bridge rights afforded all employees hired before January 1, 2004. Employment as an Incumbent tolls the running of the five (5) years. An Incumbent who moves from employment by WCH to ESHI or from ESHI to WCH either as a transfer of work scope or as the result of application for an open position shall retain his or her status as an Incumbent. A quit or discharge and rehire by WCH or ESHI results in the loss of Incumbent status. A HAMTC-represented employee who was hired before January 1, 2004, and moves to a HAMTC job with WCH or ESHI under circumstances that protect his or her status as an Incumbent under the collective bargaining agreement between WCH and HAMTC will be an Incumbent.

Under Age 65 Opt-Out: An otherwise eligible participant is entitled to a one-time opt-out of post-retirement medical benefits. If an eligible participant elects to opt-out of post-retirement medical benefits, the election will apply to coverage for the retiree and the retiree's spouse/domestic partner and eligible dependents.

An eligible participant makes this election prior to their separation of employment. If the election for coverage is made prior to separation, a one-time opt-out option is still available in the future. After opting out, the retiree may re-enroll in coverage within 30 days following a qualifying life event or during an annual open enrollment period, which is effective January 1 of the following calendar year.

If coverage is dropped again for any reason, the participant may not re-enroll in medical coverage prior to attaining age 65.

Age 65 or Older Opt-Out: An otherwise eligible participant is entitled to opt-out of participation in the HEWT Retiree Health Reimbursement Arrangement at any time. An eligible participant's election to opt-out will not affect the coverage of the retiree's spouse or eligible dependents. After opting out, an eligible participant may re-enroll in coverage at any time if the individual has maintained coverage during the opt-out period or, if otherwise, during an annual open enrollment period, which is effective January 1 of the following calendar year.

If you are an eligible participant, you must elect life insurance coverage at termination of employment. If you do not enroll for life insurance when it is first available or if you allow it to be discontinued or lapse, you may not again enroll or reinstate the coverage.

Dependent Coverage: Eligible dependents are only those who were enrolled as dependents on your last day of service as an active employee, reduction-of-force, disability or other approved leave. In addition, to be an eligible dependent, individuals must also meet the applicable eligibility requirements on the date you seek to enroll them (for example, age and status).

No new dependents may be added at any time.

Your dependents, as defined below, are eligible to participate only as described in the Plans Chart (Attachment A). All dependents must also meet the requirements set forth below applicable to the type of dependent. A dependent may not be enrolled in a Plan unless you are enrolled in the Plan.

If both you and your spouse/domestic partner are eligible retirees under the age of 65, or if you are an eligible retiree and your spouse/domestic partner is an employee of a Sponsor eligible for coverage under a HEWT-administered medical plan, you may each separately maintain coverage in your respective category or one of you may be covered by the other as a dependent spouse. However, you may not be covered under both the active and retiree medical Plans. In other words, you or your spouse or dependents may not receive benefits under more than one HEWT-sponsored medical Plan.

If both you and your spouse (or former spouse)/domestic partner are covered by a HEWT-sponsored medical plan, your children may be enrolled as dependents under one Plan, but not more than one medical Plan. Your child cannot be covered as a dependent if that child is eligible for coverage as an employee under any Sponsor's group medical plan.

At age 65, your dependent child may only continue coverage under the HEWT-administered medical plan for retirees if he or she has been pre-approved under the plan as disabled.

Eligible dependents include the following individuals who were covered as a dependent at the time of your retirement:

- Your legal **spouse,** unless he or she is enrolled in one of the Plans as an employee or retiree;

- Your **registered domestic partner** (as recognized by Washington State law), up to the attainment of age of 65, if you retire on or after January 1, 2010;

- An **unmarried child(ren)**, under age 23 (or age 25 for benefits offered by Group Health), if you provide more than fifty percent (50%) of their support and maintenance, provided they are not:

  - In active duty military service, or

  - Employed full-time, or

  - Eligible for any other group health benefits through their employer.

  The term child(ren) means: a natural child or legally adopted child who resides in your home, and other children where you or your spouse/domestic partner has legal guardianship, custody, or conservatorship evidenced by a court order.

- Coverage can be continued for **child(ren) age 23** (or age 25 for benefits offered by Group Health) **or more years old** if the child is not able to be self-supporting by reason of a **mental or physical disability**, provided:

  - the disability existed before age 23 (or age 25, as applicable), and

  - the child was covered as a dependent prior to reaching age 23 (or age 25, as applicable), and

  - the child is principally dependent on you for support, and

  - proof of the child's condition and dependence is submitted prior to the date coverage would otherwise have ended.

  We may require that the child be examined by a physician chosen by us at our cost. You may be required to continue to provide proof that the child meets the conditions of incapacity and dependency. If you do not provide proof of the child's incapacity and dependency within 30 days of request, coverage for the child will end.

A child will cease to be a dependent upon your age 65th birthday (unless the child has qualified as disabled under the medical plan), their marriage, their full-time employment with another employer, their eligibility for any other group medical plan through their employer, or by their enlistment in military service.

Note: Military Service means the performance of duty on a voluntary or involuntary basis in the uniformed services, including active duty, active and inactive duty for training, National Guard duty under federal statute, and any period for which a person is absent from employment for an examination to determine fitness to perform such duty. Uniformed services includes the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for

training, inactive duty for training, or full-time National Guard duty; the Commissioned Corps of the Public Health Service; and any other category of persons designated by the President in time of war or national emergency.

HEALTH BENEFITS

Under Age 65: A retiree who is under the age of 65 may cover a spouse/domestic partner and eligible dependent children under the same medical plan in which he or she is enrolled but only if the spouse/domestic partner and dependent children are covered under the Employer's medical plan for employees at the time the retiree ends recognized employment service. The retiree may not add new dependents.

Once a spouse attains age 65, he or she is no longer eligible for HEWT group post-retirement insurance coverage and must enroll in the HEWT Retiree Health Reimbursement Arrangement in order to continue to receive any benefits.

Once a domestic partner attains age 65, he or she is no longer eligible HEWT group post-retirement insurance coverage.

Age 65 or Older: A retiree who is at least age 65 and enrolled in Medicare Parts A and B, is no longer eligible for HEWT group post-retirement insurance coverage. Instead, he or she is eligible to participate in the HEWT Retiree Health Reimbursement Arrangement. Through the HEWT Retiree Health Reimbursement Arrangement, the retiree may purchase individual insurance through ExtendHealth and receive reimbursement for other uninsured medical expenses. The retiree may continue HEWT post-retirement insurance coverage for his or her spouse/domestic partner until the spouse/domestic partner is age 65.

Dependent children are not eligible for HEWT post-retirement insurance coverage for a retiree who is age 65 or older, with the following one exception:

- Children who are permanently physically, mentally, or developmentally disabled, and
- continuously covered under a HEWT-sponsored medical plan for employees, and
- for whom the retiree is providing full support.

Death

If you die, your covered surviving spouse/domestic partner may continue coverage until the earlier of his or her attainment of age 65, remarriage, or in the case of a domestic partner, the domestic partner enters into a new registered domestic partnership, or the plan is terminated.

Age 65 or Older at time of death--Spouse: If you and your surviving spouse are age 65 or older at the time of your death, and you are participating in the HEWT Retiree Health Reimbursement Arrangement, in the year of your death your surviving spouse may use the entire amount credited

on your behalf to that account, minus any claims for uninsured medical expenses, that you have submitted for reimbursement up to the date of your death. Your surviving spouse will continue to be eligible to participate in the HEWT Retiree Health Reimbursement Arrangement each subsequent year until the earlier of the date he or she remarries or dies.

Under Age 65 at time of death --Spouse/Domestic Partner: If at the time of your death your surviving spouse/domestic partner is under the age of 65 and he or she, along with your eligible dependent children, are participating in the HEWT post-retirement insurance plan, your surviving spouse/domestic partner may continue coverage under the HEWT post-retiree medical plan until he or she attains age 65 and is Medicare eligible. Upon attainment of age 65 and Medicare eligibility, your surviving spouse will be eligible for the HEWT Retiree Health Reimbursement Arrangement.

Domestic Partners will no longer be eligible for coverage under the HEWT post-retirement insurance plan upon attainment of age 65 nor will he or she will be eligible for the HEWT Retiree Health Reimbursement Arrangement.

Your covered dependent children may elect to continue coverage beyond your death, as follows:

Under age 65—Dependent Children: If you are under age 65 at the time of your death and you have a surviving spouse/domestic partner, your eligible dependent child will remain covered under the plan until you, the retiree, would have turned age 65, or the dependent child reaches the limiting age (age 23 or 25, depending on the medical plan).

When your eligible dependent child's coverage ends as of the date that you would have turned age 65, he or she will be offered COBRA coverage if your date of death was within 36 months of the date you would have turned age 65. The duration of coverage will be up to 36 months from your date of death.

If at the time of your death, you do not have a surviving spouse/domestic partner, your eligible dependent child may continue coverage under the Plan for up to 36 months under COBRA. The eligible dependent child will be responsible for paying the applicable COBRA premiums.

Age 65 or Older---Dependent Children: Any eligible dependent child participating in the HEWT post-retirement insurance plan at your death may remain on that plan until the earlier of his or her loss of dependent status or your surviving spouse's/domestic partner's death.

DEPENDENT LIFE INSURANCE

Your spouse/domestic partner and dependents may qualify for continued dependent life insurance. See Attachment A and the definition of "dependent" in the applicable certificate of coverage.

DISQUALIFICATION OF BENEFITS

A retiree's coverage in the applicable Plans will end in the following circumstances:

- In accordance with the terms of the applicable SPD.
- The retiree no longer meets the Plan's eligibility requirements.
- The retiree is rehired as a regular employee with a Plan Sponsor.
- The Plan Sponsors terminate the Plan.
- The retiree does not make his or her election for eligible coverages prior to his or her last day worked.
- The required premiums are not paid within 45 days of the due date.
- The retiree meets the lifetime maximum.
- As a result of material misrepresentation, fraud, or omission of information in order to obtain coverage for a participant or others.
- For permitting the use of a plan's identification card or number by another person, or using another person's identification card or number in order to obtain benefits to which one is not entitled.
- In cases where a participant commits acts of physical or verbal abuse that pose a threat to the claim administrator, an insurance provider, or the Plan Administrator or staff.
- The retiree dies.

An eligible dependent's coverage in the applicable Plans will end in the following circumstances:

- In accordance with the terms of the applicable SPD.
- In the case of your surviving spouse/domestic partner, the surviving spouse/domestic partner remarries or enters into a new registered domestic partnership.
- In the case of your domestic partner, the domestic partner attains age 65.
- In the case of an eligible dependent child who is participating in the Plan as the result of your death as a retirement eligible active employee (only applies to employees hired before January 1, 2004), coverage will terminate on the date you would have attained age 65.

- The retiree is rehired as a regular employee with a Plan Sponsor.
- The Plan Sponsors terminate the Plan.
- The retiree does not make his or her election for eligible coverages prior to his or her last day worked.
- The required premiums are not paid within 45 days of the due date.
- The enrolled dependent no longer meets the requirements to remain an eligible dependent.
- The participant meets the lifetime maximum under the applicable policy.
- As a result of material misrepresentation, fraud, or omission of information in order to obtain coverage for a participant or others.
- For permitting the use of a plan's identification card or number by another person, or using another person's identification card or number in order to obtain benefits to which one is not entitled.
- In cases where a participant commits acts of physical or verbal abuse that pose a threat to the claim administrator, an insurance provider, or the Plan Administrator or staff.
- The spouse/domestic partner or eligible dependent child dies.

TYPE OF PLAN ADMINISTRATION

The type of administration (for example, contract administration, insurer administration) of each Plan is described in the Plans Chart (Attachment A).

NAME AND ADDRESS OF AGENT FOR LEGAL PROCESS

The name and address of the agent for service of legal process for the Plans is:

Mr. Jason Froggatt
Davis Wright Tremaine LLP
Suite 2200
1201 Third Avenue
Seattle, WA 98101

Legal process may also be served upon a Plan Trustee or the Plan Administrator.

PLAN DOCUMENTS

The Plan documents consist of this document, the summary plan descriptions, certificates of insurance/coverage, group insurance contracts, the Trust Agreement and the formal interpretations adopted by the Plan Administrator. Upon written request to the Plan Administrator, copies of any or all of the Plan documents will be furnished to a Plan participant or beneficiary at a charge to the requestor.

AMENDMENT AND TERMINATION OF THE PLANS

The Trust and the Sponsors have established the Plans with the bona fide intention and expectation that they will be continued indefinitely, but they reserve the right to terminate all or any of the Plans, in whole or in part, at any time, without liability. This includes, without limitation, the right to increase or decrease the Sponsors' contributions or the participants' contributions to all or any of the Plans, at any time, and to modify all or any part of the coverage with respect to any or all of the participants covered by a Plan or Plans. Any termination will be in accordance with the provisions of the Trust and the agreements under which the Sponsors adopted the Plans (the "Adoption Agreements"). Any amendment, modification or termination will be approved by the Trust and the Sponsors, as applicable, in accordance with the Trust Agreement, the Adoption Agreements, and the normal procedures of the Trust and the Sponsors for transacting business.

Upon termination or discontinuance of any Plan, you will not have any further rights, other than for the payment of benefits for covered losses or expenses incurred before such Plan was terminated. The amount and form of any final benefit you or your beneficiary receive will depend on the Plan Documents and the Plan Administrator's decisions.

CLAIMING BENEFITS

You or your beneficiary must file the appropriate forms to receive any benefits or to take any other action under any of the Plans, as described in the applicable SPD or certificate of insurance. Completed forms should be submitted to the appropriate entity described in the applicable SPD or certificate of insurance. Generally, you or your provider on your behalf will initiate a claim for benefits with the applicable party administering the benefit plan (the claims administrator or insurance company). Please review the SPD or certificate of insurance to determine exactly how to initiate a claim for benefits.

You must exhaust all of the claims review procedures described in the applicable SPD, certificate of insurance and this document before you are entitled to initiate a lawsuit in state or federal court. If there are no claim and/or review procedures set forth in the SPD or certificate of insurance, you may follow the procedure set forth below. In some instances, after you have exhausted your claim and appeal rights before the claims administrator or insurance company, you may be entitled to a final appeal to the Plan Administrator. Consult the applicable SPD or certificate of insurance.

APPEAL PROCEDURES

Before you are entitled to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act, you must exhaust all of the claims review procedures described here or in the applicable SPD or certificate of insurance.

Eligibility Appeals

Your eligibility appeal request must be submitted to the Plan Administrator within 60 days from the receipt of the eligibility decision. You will need to provide written comments, documents, records and other information relating to your appeal to the HEWT Plan Administrator, P.O. Box 650 (H2-23), Attention: Appeals, Richland, Washington 99352.

You will receive notification of the Plan Administrator's decision on your appeal not later than 30 days after receipt by the Plan Administrator of your request for review unless the Plan Administrator determines that special circumstances (such as the need to hold a hearing) require an extension of time, in which you will be notified prior to the termination of the initial review period. Notice shall be provided to you in writing or electronically.

In the case of an adverse decision on your request for review, the notice shall:

- Specify the reason or reasons for the adverse eligibility determination.
- Provide you reference to the specific Plan provisions on which the determination is based.
- Provide you with a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the review.

In the event that you are not satisfied with the disposition of your appeal, you are entitled to initiate a lawsuit under Section 502(a) of the Employee Retirement Income Security Act.

Health Benefits

Urgent Claims

If your appeal involves an urgent claim that requires immediate action, all levels of appeal have been delegated to the claims administrator or insurance company that is responsible for paying claims. The claims administrator or insurance company's decisions are conclusive and binding. Consult the applicable SPD.

Pre-Service and Post-Service Claims – Insured Health Benefits

If your appeal involves a non-urgent claim and you are participating in an insured group health plan (currently Group Health Cooperative), all levels of appeal have been delegated to the

insurance company that is responsible for paying claims. The insurance company's decisions are conclusive and binding. Consult the applicable certificate of coverage.

Pre-Service and Post-Service Claims – Self-Insured Health Plan

If your appeal involves a non-urgent claim under the self-insured health plans currently administered by United-Healthcare, and you are not satisfied with the first level appeal decision of the claims administrator or the insurance company, you have the right to request a second level appeal to the Plan Administrator. Your second level appeal request must be submitted to the Plan Administrator within 60 days from the receipt of the first level appeal decision, or, if later, within 180 days following the initial adverse benefit determination. You will be provided the following:

- The opportunity to submit written comments, documents, records and other information that were submitted to United Healthcare in connection with your first (1^{st}) appeal.
- To receive upon request and free of charge reasonable access to, and copies of, all documents, records and other information relevant to your appeal.
- A review that takes into account all comments, documents, records and all other information relating to the claim submitted by you at the time of your first (1^{st}) appeal to United Healthcare.
- A review conducted by the Plan Administrator that does not afford deference to the initial adverse benefit determination.
- If the appeal is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate, the Plan Administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.
- The Plan Administrator will identify all medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination without regard to whether the advice was relied upon.
- Any health care professional engaged for purposes of a consultation with respect to your appeal will be an individual who is neither an individual who was consulted in connection with the initial adverse benefit determination nor a subordinate of such individual.

You will receive notification of the Plan Administrator's decision on your appeal not later than 30 days after receipt by the Plan Administrator of your request for review unless the Plan Administrator determines that special circumstances (such as the need to hold a hearing) require

an extension of time, in which you will be notified prior to the termination of the initial review period. Notice shall be provided to you in writing or electronically.

In the case of an adverse decision on your request for review, the notice shall:

- Specify the reason or reasons for the adverse determination.
- Provide you with a reference to the specific Plan provisions on which the determination is based.
- Provide you with a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the review.

In the event that you are not satisfied with the disposition of your appeal, you are entitled to initiate a lawsuit under Section 502(a) of the Employee Retirement Income Security Act.

Pharmacy Benefit Program

If you are not satisfied with the disposition of your claim for benefits under the Pharmacy Benefit Program as administered by Express Scripts (ESI), contact ESI at 1-800-796-7518 to confirm claim denial. If you are not satisfied with the first level appeal decision made by ESI, you have the right to request a second level appeal to the Plan Administrator. You have the right to one appeal to the Plan Administrator. Your second level appeal request must be submitted to the Plan Administrator within 60 days from your receipt of the denial of your claim by ESI, or, if later, within 180 days following the initial adverse benefit determination. In your letter of appeal to the Plan Administrator, include the following information:

- Patient's name and the identification number from the Prescription ID card
- The date(s) of service(s)
- Documentation from ESI denying claim
- The reason you believe the prescription should be covered under the Plan
- Any documentation or other written information to support your request

Send the written appeal and documentation to:

HEWT Plan Administrator
Attn: Appeals
P.O. Box 650 (H2-23)
Richland, WA 99352

You will be provided the following:

- The opportunity to submit written comments, documents, records and other information that were submitted to ESI in connection with your first 1st appeal to ESI.

- To receive upon request and free of charge reasonable access to, and copies of, all documents, records and other information relevant to your appeal.

- A review that takes into account all comments, documents, records and all other information relating to the claim submitted by you at the time of your first (1st) appeal to ESI.

- A review conducted by the Plan Administrator that does not afford deference to the initial adverse benefit determination.

- If the appeal is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate, the Plan Administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

- The Plan Administrator will identify all medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination without regard to whether the advice was relied upon.

- Any health care professional engaged for purposes of a consultation with respect to your appeal will be an individual who is neither an individual who was consulted in connection with the initial adverse benefit determination nor a subordinate of such individual.

You will receive notification of the Plan Administrator's decision on your appeal of ESI's determination not later than 30 days after receipt by the Plan Administrator of your request for review unless the Plan Administrator determines that special circumstances (such as the need to hold a hearing) require an extension of time, in which you will be notified prior to the termination of the initial review period. Notice shall be provided to you in writing or electronically.

In the case of an adverse decision on your request for review, the notice shall:

- Specify the reason or reasons for the adverse determination.

- Provide you with a reference to the specific Plan provisions on which the determination is based.

- Provide you with a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the review.

In the event that you are not satisfied with the disposition of your appeal, you are entitled to initiate a lawsuit under Section 502(a) of the Employee Retirement Income Security Act.

Life Insurance

Whenever a claim is denied, you have the right to appeal the decision. You (or your duly authorized representative) must make a written request for appeal to the Insurance Company within 60 days from the date you receive the denial. If you do not make this request within that time, you will have waived your right to appeal.

Once your request has been received by the Insurance Company, a prompt and complete review of your claim must take place. This review will give no deference to the original claim decision, and will not be made by the person who made the initial claim decision. During the review, you (or your duly authorized representative) have the right to review any documents that have a bearing on the claim, including the documents which establish and control the Plan. Any medical or vocational experts consulted by the Insurance Company will be identified. You may also submit issues and comments that you feel might affect the outcome of the review.

The Insurance Company has 60 days from the date it receives your request to review your claim and notify you of its decision. Under special circumstances, the Insurance Company may require more time to review your claim. If this should happen, the Insurance Company must notify you, in writing, that its review period has been extended for an additional 60 days. Once its review is complete, the Insurance Company must notify you, in writing, of the results of the review and indicate the Plan provisions upon which it based its decision.

RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 ("ERISA")

As a participant in the Plans, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants are entitled to:

- Examine without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all Plan Documents, including insurance contracts, collective bargaining agreements, and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary financial report.

- Continue health coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. There is a detailed description of your COBRA rights at page 20 of this document.

This Plan does not contain any elimination or exclusionary period of coverage for preexisting conditions. However, you may be subject to such restrictions if you leave the Plan to join another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to draw COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the Publications Hotline of the Employee Benefits Security Administration.

SPECIAL PROVISIONS APPLICABLE TO GROUP HEALTH PLANS

The following provisions apply only to Plans that are group health plans (each of which is a "Health Plan"), and shall supersede any inconsistent provisions in the Summary Plan Descriptions for Health Plans.

Death

If you die, your covered dependents may elect to continue coverage beyond your death. The election must be in writing and within 31 days after coverage would otherwise end as a result of your death. Coverage is dependent upon payment of required contributions. Coverage will end for your spouse/domestic partner upon his or her remarriage or entering into a new registered domestic partnership. Remarriage of your surviving spouse or entering into a new registered domestic partnership will not render other dependents ineligible. However, coverage for other dependents will end when the dependents no longer meet the eligibility criteria to qualify as a dependent. This period of coverage will be credited toward satisfying the maximum coverage provided under COBRA discussed below.

COBRA Continuation Coverage Eligibility

Eligibility.

If you are the spouse of a retiree covered by the Health Plan, you have the right to elect COBRA continuation coverage for yourself if you lose your group health coverage under the Health Plan for any of the following qualifying events:

- The death of your spouse;
- Divorce or legal separation from your spouse; or
- Your spouse becomes entitled to and enrolls in Medicare benefits under Title XVIII of the Social Security Act.

A dependent child of a retiree covered by the Health Plan has the right to elect COBRA continuation coverage if the dependent child's group health coverage under the Health Plan is lost for any of the following qualifying events:

- The death of the employee-parent;
- The parents' divorce or legal separation;
- The employee-parent becomes entitled to and enrolls in Medicare benefits under Title XVIII of the Social Security Act; or
- The dependent ceases to be a "dependent child" under the Health Plan.

Electing COBRA Continuation Coverage.

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The covered retiree or a covered family member has the responsibility to provide written notice of the retiree's divorce or legal separation, or a child losing dependent status under the Plan. This written notice must be provided to the Plan Administrator (as described below) within 60 days after the later of (1) the date of such an event, or (2) the date on which the affected retiree or family member would otherwise lose coverage because of such event. If this notice is not given to the Plan Administrator within the required 60-day period, the affected retiree or family member will not be entitled to elect COBRA continuation coverage.

If a covered retiree or covered family member provides notice of the retiree's divorce or legal separation, or a child losing dependent status under the Plan, and COBRA continuation coverage is not available, the retiree or covered family member will be notified by the Plan Administrator that COBRA continuation coverage is not available.

The Employer has the responsibility to notify the Plan Administrator of the retiree's death, or the retiree becoming entitled to and enrolling in Medicare under Title XVIII of the Social Security Act.

When the Plan Administrator is notified that one of these qualifying events has occurred, the Plan Administrator will in turn notify the appropriate individuals (also called "qualified beneficiaries") that they have the right to elect COBRA continuation coverage. COBRA continuation coverage must be elected by such individuals within 60 days after the later of (1) the date that coverage under the Health Plan would otherwise terminate due to the qualifying event, or (2) the date that these individuals are provided with written notification of their right to elect COBRA continuation coverage. If COBRA continuation coverage is not elected within this 60-day period, the Health Plan coverage will end retroactive to the date that coverage would have otherwise ended due to the COBRA qualifying event, and the affected family member will not be entitled to elect COBRA continuation coverage. While an election by a covered spouse will be treated as an election of COBRA continuation coverage by the entire family, each family member may make a separate election as to COBRA continuation coverage. This means that a covered spouse or dependent child may separately elect COBRA continuation coverage. A covered spouse or dependent may elect COBRA continuation coverage even if covered under another group health plan or Medicare prior to electing COBRA continuation coverage.

Duration of Coverage.

If continuation of coverage is elected, the Health Plan is required to provide COBRA continuation coverage which, at the time that coverage is being provided, is identical to the coverage provided under the Health Plan to similarly situated Health Plan participants who have not experienced a qualifying event (called "non-COBRA beneficiaries"). For example, if a retiree dies leaving a spouse and two dependent children covered under the Health Plan, they would be entitled to the same benefits as the covered spouse and dependent children of a retiree.

If the benefits for similarly situated non-COBRA beneficiaries are modified, the changes will apply to those who have COBRA continuation coverage as well.

COBRA continuation coverage may be maintained for up to 36 months.

In general, you and your covered dependents (if any) will only be given an opportunity to continue the coverage they each were receiving immediately before the qualifying event. In a few circumstances, however, they may elect alternative coverage that the Plan makes available to retirees, such as:

(1) If you participate in a region-specific HMO that will not service your health needs in the area to which you are relocating, you must be given an opportunity to elect alternative coverage that the employer makes available to active employees.

(2) The retiree's covered dependents (if any) will have the same opportunity as a retiree to change their coverage at open enrollment.

When COBRA Continuation Coverage Ends.

The law provides that COBRA continuation coverage will be cut short for any of the following reasons:

(1) Your former Employer no longer provides group health coverage to any of its employees;

(2) The premium for the COBRA continuation coverage is not paid on a timely basis (The first premium payment is payable in a lump sum 45 days after electing COBRA continuation coverage; all subsequent premium payments are due on the first day of the month. There is a 45-day grace period for premium payments. Premium payments must be paid no later than forty-five (45) days after the first day of the month to which they apply);

(3) The covered individual first becomes, after the date of the COBRA continuation coverage election, covered under another group health plan (as an employee or otherwise) that does not contain any exclusion or limitation with respect to any pre-existing condition of that individual (other than an exclusion or limitation that does not apply to, or is satisfied by, such individual by reason of the Health Insurance Portability and Accountability Act of 1996);

(4) The covered individual first becomes, after the date of the COBRA continuation coverage election, entitled to and enrolls in Medicare (under Title XVIII of the Social Security Act); or

(5) Upon the occurrence of any event (such as submission of fraudulent claims) by a covered individual that permits termination of Health Plan coverage for cause with respect to similarly situated non-COBRA beneficiaries.

If your COBRA continuation coverage ends before the expiration of the 36-month period, the Plan Administrator will provide you notice of termination of coverage as soon as practicable.

Covered individuals should provide written notice to the Plan Administrator if an event occurs that is listed in number (3) or (4) above within 30 days after becoming eligible for such other group health plan coverage or entitled to Medicare.

In the event that you fail to timely notify the Plan Administrator that you are no longer eligible for COBRA coverage as a result of events described in either paragraph numbers (3) or (4), the Plan has the right to seek reimbursement for any benefits provided to you by the Plan during the period you were not eligible for coverage.

Cost of Coverage.

The cost of COBRA continuation coverage will generally not exceed 102% of the cost for coverage under the Health Plan. The cost of COBRA continuation coverage will increase in the middle of the 12-month determination period only in the following instances:

(1) where the qualified beneficiary changes to more expensive coverage, or

(2) where the Health Plan was previously requiring payment of less than the maximum permissible amount.

Except when under the terms of the Plan an individual is eligible for employer-paid COBRA coverage, an individual seeking COBRA continuation coverage is liable for the cost of that coverage during the entire applicable 36-month period (measured from the date that coverage would otherwise end due to the qualifying event). Due to the required 60-day COBRA election period, it is likely that a covered individual will be responsible for retroactive premiums. These premiums must be paid in a lump sum within 45 days after electing COBRA continuation coverage in order for the COBRA continuation coverage to be effective. After that payment, premiums are due on a monthly basis. Coverage will terminate if premiums are not paid within 45 days after the date they are due.

An individual need not show proof of insurability to elect COBRA continuation coverage.

Effect of COBRA Continuation Coverage on Other Rights Under Federal Law.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you may lose the right to avoid having preexisting condition exclusions applied to you by other group health plans. If you have more than a 63-day gap in health coverage, an election of continuation coverage may help you not to have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such preexisting condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you may have special enrollment rights under federal law. You have the right to request special enrollment in another group

health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of a qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

Coverage Expires.

When COBRA continuation coverage expires after 36 months, an individual may have the opportunity to enroll in an individual conversion health plan provided by the Health Plan provided such option is otherwise generally available to similarly situated non-COBRA beneficiaries under the group health plan.

If You Have Questions.

Questions concerning your health plan or your COBRA continuation rights should be addressed to the Plan Administrator. For more information about your rights under ERISA, including COBRA, the Privacy Rule under Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest regional or district office of the U.S. Department of Labor's Employee Benefit Security Administration (EBSA), or visit the EBSA website at www.dol.gov/ebsa.

Notices to the Plan Administrator.

Any notices that a retiree or covered family member must make to the Plan Administrator (including notice of the retiree's divorce or legal separation, or a child losing dependent status) should be delivered to the following address:

HEWT Plan Administrator
P.O. Box 650, MSIN: H2-23
Richland, WA 99352
Attn: COBRA Administrator

When providing notification to the Plan Administrator of the retiree's divorce or legal separation, or a child losing dependent status, you must complete a Notice of Qualifying Event Form. The Notice of Qualifying Event Form is available from the Plan Administrator.

Any questions or complaints that a retiree or eligible dependent has relating to his or her rights under the HIPAA Privacy Rule should be directed to the Plan's HIPAA Privacy Officer at the following address:

HEWT Plan Administrator
P.O. Box 650, MSIN: H2-23
Richland, WA 99352
Attn: HIPAA Privacy Officer

Address Changes.

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy for your records of any notices you send to the Plan Administrator.

Newborns' and Mothers' Health Protection Act of 1996

For Insured Plans that provide maternity or newborn infant coverage, special rights upon childbirth under the Newborns' and Mothers' Health Protection Act of 1996, as amended, and state law, as applicable, are described in the SPDs for the applicable Insured Plan. For Self-Insured Plans that provide maternity or newborn infant coverage, special rights upon childbirth are described below:

Special Rights Upon Childbirth: Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Privacy

The Health Plan is required by law to protect the privacy of certain health information that it may use or disclose. Retirees will be provided with a Notice of Privacy Practices within 90 days of enrollment in the Health Plan that describes how the Health Plan may use or disclose your health information, your rights with respect to your health information, and the Health Plan's duties with respect to your health information. To get a copy of the notice, or if you have questions regarding the protection of your health information, you may contact the Health Plan Privacy Officer at (509) 372-8284.

Attachment A

PLANS CHART

Plan Name, Number and Participants	Plan Type and Type of Administration	Sources of Contributions	Payment of Benefits
1. HEWT "Options PPO" Plan for Retirees This Plan covers retired employees who are under age 65 and their eligible dependents. See Eligibility Section. Plan No. 551	Health, mental health and substance abuse benefits. Claims Administration (except Prescription Drugs) by United Healthcare. Prescription Drugs benefits administered by Express Scripts, Inc.	Sponsors Participants	Self-insured by your Sponsor (i.e., benefits are paid from retiree contributions, if any, and the Sponsor's general assets) and are funded through the Hanford Employee Welfare Trust (HEWT). United Healthcare provides administrative services only for health benefits. Express Scripts, Inc. provides administrative services only for retail and mail order prescription drug benefits. United Healthcare's address is: P.O. Box 30555 Salt Lake City, UT 84130-0555 Express Scripts' address is: P.O. Box 390873 Bloomington, MN 55439
2. HEWT Retiree Health Reimbursement Arrangement This Plan covers retired employees who are age 65 or older and eligible for Medicare Parts A and B, and their eligible spouses. See Eligibility Section. Plan No. 551	Health, mental health and substance abuse benefits. Claims Administration by ExtendHealth.	Sponsors	Self-insured by your Sponsor (i.e., benefits are paid from retiree contributions, if any, and the Sponsor's general assets) and are funded through the Hanford Employee Welfare Trust (HEWT). ExtendHealth provides administrative services for health benefits. ExtendHealth's address is: 10975 South Sterling View Drive Suite A-1 South Jordan, UT 84905

Plan Name, Number and Participants	Plan Type and Type of Administration	Sources of Contributions	Payment of Benefits
3. Group Health Cooperative (GH) "Options" Point of Service Plan This Plan covers retirees who are under age 65 and not eligible for Medicare Plan No. 551	Provides health, vision exam, prescription drug and mental health and substance abuse benefits. Insurer administration	Sponsors Participants	Insured GH insures benefits through an insurance policy. It also administers the plan, including payment of claims. GH's address: Group Health Cooperative 1009 Center Parkway Kennewick, WA 99336
4. Basic Group Life Basic Group Life covers all retirees. Plan No. 551	Provides life insurance benefits. Insurer administration	Sponsors Participants	Insured CIGNA insures the benefits through an insurance policy. It also administers the plan. CIGNA's administrative services include: claim administration, cost containment, financial, banking, billing administration and payment of claims. CIGNA's address is: Life Insurance Company of North America 1601 Chestnut Street Philadelphia, PA 19192-2235
5. Dependent Life Insurance Plan This is available to retirees under age 65, only.	This provides dependent life insurance benefits. Insurer administration	Participants	Insured Same as 4, above.
6. Accelerated Life Insurance Benefit (ALIB)	Provides life insurance benefits. Insurer administration	Sponsors	Insured. Same as 4, above.

Attachment B

SPONSORS CHART

Name of Sponsor	Employer Identification Number	Address
Fluor Hanford, Inc.	33-0691003	P.O. Box 1000, E6-41 Richland, WA 99352
Washington Closure Hanford, LLC	20-1666939	2620 Fermi Avenue Richland, WA 99354
Eberline Services Hanford, Inc.	91-1688187	2620 Fermi Avenue Richland, WA 99354
CH2M HILL Hanford Group, Inc.	91-1733503	P.O. Box 1500, H7-30 Richland, WA 99352
Johnson Controls, Inc.	39-0380010	P.O. Box 750 Richland, WA 99352
Energy Northwest (Standards Lab)	91-6018049	P.O. Box 968 North Power Plant Loop Richland, WA 99352
Parsons Fabricators Hanford, Inc.	20-0561678	3005 East Ainsworth Street Warehouse S Pasco, WA 99301
Advanced Technologies and Laboratories International, Inc.	51-032-3647	555 Quince Road, Suite 500 Gaithersburg, MD 20878
CH2M Hill Plateau Remediation Company (CHPRC)	77-0694488	P.O. Box 1600, H8-17 Richland, WA 99352
M&EC PRC, Inc.	26-3179694	c/o Perma-Fix Environmental Services, Inc. 701 Scarboro Road, #300 Oak Ridge, TN 37830
Babcock Services PRC, LLC	01-0912203	1840 Terminal Drive Richland, WA 99354
EnRep PRC, Inc.	26-3176568	3190 George Washington Way Sigma 1/Room 2 Richland, WA 99352
Cavanaugh Services Group PRC, LLC	26-3190484	180 South 300 West, #290 Salt Lake City, UT 84101
GEM Technology – PRC, Inc.	26-3190138	2800 Ponce DeLeon Blvd., Suite 1100 Coral Gables, FL 33134
Washington River Protection *Solutions*, LLC	26-0771181	1200 Jadwin Avenue Richland, WA 99352
Mission Support Alliance, LLC	30-0419594	P. O. Box 650, H2-23 Richland, WA 99352
Abadan Hanford, LLC	27-0481852	79 Aaron Drive Richland, WA 99352
Akima Hanford Services, LLC	27-0476876	2490 Garlick Blvd. Richland, WA 99354
Dade Moeller & Associates Hanford Mission Support, LLC	27-0470310	1835 Terminal Drive Richland, WA 99354
CSC Hanford, LLC	27-0504938	P.O. Box 650, R3-13 Richland, WA 99352
HPM Corporation – MSA	80-0433252	2625 W. Entiat Avenue

Name of Sponsor	Employer Identification Number	Address
		Kennewick, WA 99336
PSI-Hanford, Inc.	27-0452761	2780 Barnes Blvd. S.W. Building G Tumwater, WA 98512
R.J. Lee Group, Inc.-MSA	27-0478298	2710 N. 20th Avenue Pasco, WA 99301
Westech International MSA, LLC	27-0481996	825 Jadwin Avenue MSC A6-06 Richland, WA 99352